School Based Services
Appendices

Appendix 1
National HCFA 1500 Claim Form Sample

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name. First Name. Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name. First Name. Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name. First Name. Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB-1500

Appendix 1A
National HCFA 1500 Claim Form (Completed)

APPROVED OMB-0938-0008

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY / STATE

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY / STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX)XXX-XXXX

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-D

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO — If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. [S1] . — 3. . —

2. . — 4. . —

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 01 96	02 07 12	0	1	W6053		1	XXXX	4				
2 08 01 96		0	1	W6056		1	XXXX	1.5				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER — SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE: $ XXXX

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized — MM/DD/YY

SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555

PIN# — GRP# 76543218

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — ***PLEASE PRINT OR TYPE*** — FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 2
National HCFA 1500 Claim Form Completion Instructions for School Based Services

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Wisconsin Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers should always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Providers may also check Volume Eligibility on a monthly basis in lieu of seeing the card.

Element 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "M" in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number
Enter the recipient's ten-digit identification number from the current identification card.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) from the current identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address (not required)

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Bill health insurance (commercial insurance coverage) before billing Wisconsin Medicaid, unless the service does not require health insurance billing. Refer to the Coordination of Benefits Material in Section III of this handbook for more information.

- Leave this element blank when the provider has not billed the health insurance because the "Other Coverage" of the recipient's identification card is blank, the service does not require health insurance billing or the recipient's identification card indicates "DEN" (dental insurance) only.

- When "Other Coverage" on the recipient's identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing indicate one of the following codes in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by the health insurance. The amount paid by the health insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by the health insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES, the card indicates health insurance but it was not billed for reasons including, but not limited to: ◆ recipient denies coverage or will not cooperate; ◆ the provider knows the service in question is noncovered by the carrier; ◆ health insurance failed to respond to initial and follow-up claim; or ◆ benefits not assignable or cannot get an assignment.

- When "Other Coverage" on the recipient's identification card indicates "HMO" or "HMP", indicate one of the following disclaimer codes, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is entered on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not provided by a designated provider. Wisconsin Medicaid does not pay for services covered by an HMO or HMP except for the copayment and deductible amounts.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group or FECA Number (not required)

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Wisconsin Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient has had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source (not required)

Element 17a - I.D. Number of Referring Physician (not required)

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use (not required)

Element 20 - Outside Lab (not required)

Element 21 - Diagnosis or Nature of Illness or Injury

Enter diagnosis code S11 (which means this is a school based service) unless the recipient has a medical status code of TR. When billing covered nursing services for a recipient with a TR medical status code, indicate the appropriate tuberculosis diagnosis code in Appendix 5 of this handbook.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization (not required)

Element 24A - Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same emergency indicator.

Element 24B - Place of Service

Enter place of service "0".

Element 24C - Type of Service Code

Enter the appropriate single-digit type of service code. TOS 1 should be used if you are being paid the statewide contract rate. If you are billing a district-specific cost-based rate, use TOS 9. Refer to Appendix 3 for allowable TOS codes.

Element 24D - Procedures, Services, or Supplies

Enter the appropriate five-character procedure code. Refer to Appendix 4 of this handbook for a list of allowable procedure codes for SBS services. For durable medical equipment (DME), submit a paper claim and attach the item name, model number or description, and the invoice, receipt or cost.

Element 24E - Diagnosis Code

When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3 or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24F - Charges

Enter the total charge for each line. Examples: For schools using the statewide rate, multiply that rate by the number of SBS service units for each line. For schools using a district-specific rate, multiply that rate by the number of SBS service units on that line.

Element 24G - Days or Units
Enter the total number of services billed for each line. Indicate a decimal only when a fraction of a whole unit is billed. Providers should round to the nearest whole or half unit. Refer to Appendix 6 of this handbook for units of service.

Element 24H - EPSDT/Family Planning (not required)

Element 24I - EMG (not required)

Element 24J - COB (not required)

Element 24K - Reserved for Local Use (not required)

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No. (optional)
The provider may enter up to 12 characters of an internal office account number for tracking payments or other purposes. For example, a CESA may assign a different account number for each school district it bills for. This number appears on the Remittance and Status Report.

Element 27 - Accept Assignment (not required)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount paid
Enter the amount paid by the health insurance. If the health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, indicate "OI-P" in element 9.)

Element 30 - Balance Due
Enter the balance due determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

Note: This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered (not required)

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code and Telephone #
Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number.

Appendix 3
Medicaid Allowable Type of Service (TOS) and Place of Service (POS) Codes

SBS Type of Service (TOS) Codes

TOS	Description
1	Reimbursed at the statewide contract rate
9	Billing a district-specified cost-based rate

SBS Place of Service (POS) Codes

POS	Description
0	Other (School)

Appendix 4
Wisconsin Medicaid Allowable Procedure Codes

Speech-Language, Audiology and Hearing Services

W6050	IEP Speech-Language, Audiology and Hearing Service: Individual
W6051	IEP Speech-Language, Audiology and Hearing Service: Group
W6052	Speech-Language, Audiology and Hearing Service: Face-to-Face M-Team Assessment and IEP Plan Development

Occupational Therapy Services

W6053	IEP Occupational Therapy Service: Individual
W6054	IEP Occupational Therapy Service: Group
W6055	Occupational Therapy: Face-to-Face M-Team Assessment and IEP Plan Development

Physical Therapy Services

W6056	IEP Physical Therapy Service: Individual
W6057	IEP Physical Therapy Service: Group
W6058	Physical Therapy: Face-to-Face M-Team Assessment and IEP Plan Development

Psychological Services

W6059	IEP Psychological Service: Individual
W6060	IEP Psychological Service: Group
W6061	Psychological Service: Face-to-Face M-Team Assessment and IEP Plan Development

Counseling Services

W6062	IEP Counseling Service: Individual
W6063	IEP Counseling Service: Group
W6064	Counseling Service: Face-to-Face M-Team Assessment and IEP Plan Development

Social Work Services

W6065	IEP Social Work Service: Individual
W6066	IEP Social Work Service: Group
W6067	Social Work; Face-to-Face M-Team Assessment and IEP Plan Development

Nursing Services

W6068	IEP Nursing Service: Care and Treatment
W6069	Nursing Service: Face-to-Face M-Team Assessment and IEP Plan Development

M-Team Assessment and IEP Plan Development, By Other School Staff

W6070 Face-to-Face M-Team Assessment and IEP Plan Development, Other Staff

Durable Medical Equipment

W6072 Durable Medical Equipment (attach the item name, model number or description and the receipt, invoice and cost)

Special Transport

W6073 Special Transport, per mile

Appendix 5
Diagnosis Codes

Diagnosis Code	Description
S11	SBS services for individuals with a medical status code other than TR
One of the following codes must be billed for nursing services related to TB, for individuals with the TR medical status code.	
V01.1	Contact with or exposure to TB
V71.2	Observation for suspected TB
V72.5	Radiological examination, not elsewhere classified
V74.1	Special screening examination for pulmonary TB
010-018.9	TB
137-137.4	Late effects of TB
771.2	Congenital TB
795.5	Nonspecific reaction to TB skin test without active TB

Appendix 6
Service Units for School Based Services

These are the units of service to be used to bill the following services. Providers may bill fractional units of time, except for durable medical equipment. Providers should round to the nearest whole or half unit. All time is for face-to-face services with the child present in the course of providing the service.

Service	Unit
Speech-Language, Audiology and Hearing Services, Occupational and Physical Therapy, Psychological Services, Counseling Services, Social Work Services, IDEA Assessment and IEP Plan Development	15 minutes = 1 unit *face-to-face time with recipient only*
Nursing Services	10 minutes = 1 unit *face-to-face time with recipient only*
Durable Medical Equipment	1 piece of equipment = 1 unit
Special Transportation	1 mile = 1 unit

Appendix 7
Optional School Based Services Activity Log

1. Month/Year 2. School's Name	3. Student's Name (Last Name, First Name, Middle Initial) 4. Student's Birth Date MM DD YY

5. Date of service			6. General service category	7. Unit of service (time, quantity, miles)	8. Group or Individual	9. Describe Specific Services Delivered; Describe Student's Response/Progress (response/progress not required for transportation)
MM	DD	YY				

10. Describe Communication with Non-School Wisconsin Medicaid Providers:

11. Clinician/Staff Signature:

Appendix 8
Sample Authorization to Access Medicaid Funds

Dear Parents:

Under a recent change in law, your local school district may bill Wisconsin Medicaid (also called Medical Assistance and Katie Beckett) for covered services provided to Medicaid-eligible children enrolled in special education programs. These services include: nursing services, therapy services, special transportation, durable medical equipment, psychological services, counseling, social work services, and developmental testing and assessment. The intent of this new law is to return federal dollars to Wisconsin and provide funding for special education.

So that we may obtain Medicaid eligibility information and, if appropriate, file claims with Medicaid for reimbursement of services provided to your child, please complete and return one copy of this form in the self-addressed envelope that is included. Please keep the second copy for your files.

If you have questions, please contact me at:_____.

Sincerely,

_____
name and title of school district contact person

(School districts should indicate on this form the information they intend to release to Medicaid.)

I, the undersigned, hereby request and authorize _____ to release to Medicaid the information indicated below:
school district

____ Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results)

____ Medical and/or related health records

____ Psychological evaluations and related reports

____ Appropriate agency reports

____ Individualized education program

____ Others (specify)

I understand that:

My consent to release this information is voluntary.
My refusal to consent will not result in denial or limitation of services for my child.
This permission is valid for one year from the date signed.
A copy of this form is as effective as the original.

Child's Name _____ Date of Birth _____

Parent's Signature _____ Date _____

Please Return to: _____

_____

_____

Appendix 9
Local Education Agency Certification of Matching Funds for School Based Services Medicaid Reimbursement

I hereby certify that:

- Local funds not less than the amount of $_____ for the fiscal year 19__ represent expenditures for Medicaid-covered services provided to Medicaid-eligible children, and consequently are eligible for federal financial participation under Title XIX of the Social Security Act;

- these local funds are not obligated to match other federal funds for any federal program; and

- these local funds are not federal funds, unless they are federal funds that are authorized by federal law to be used to match other federal funds.

_____

Signature of Local Education Agency Authorized Representative

_____

Local Education Agency Name

_____

Medicaid Provider Number

MEDICAID SCHOOL BASED SERVICES
OPTIONAL WORKSHEET FOR CALCULATION OF AVAILABLE LOCAL MATCHING EXPENDITURES

1 Name of School District or CESA

2 Medicaid provider number

3 For period — Beginning — Ending

4 Date Prepared — Prepared by

In lieu of using lines 5 to 11, expense accounts can be listed and classified into the appropriated service categories on a separate worksheet and totals transfered to line 13 below.

	Account Number (See Note Below)	Account Description	Speech	OT	PT	Psych. Counsing and Soc. Work	Dev. Testing	Nursing	Transportation	Durable Med Equipment
5			$	$	$	$	$	$	$	$
6										
7										
8										
9										
10										
11										
12	If more space needed, enter totals from additional sheet									
13	Direct cost for categories of services (total from financial records).....	13	$	$	$	$	$	$	$	$
14	Subtract: Federally reimbursed cost..(from financial records).....	14	( )	( )	( )	( )	( )	( )	( )	( )
15	Net direct cost (Line 13 - 14).....	15	$	$	$	$	$	$	$	$
16	Indirect cost percentage: Statewide Rate.....	16	. %	. %	. %	. %	. %	. %	n/a	n/a
	-OR-		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
16a	Indirect cost percentage: LEA Indirect Rate (attach worksheet)....	16a							n/a	n/a
17	Indirect cost calculated (Line 15 x 16 or 16a).....	17	$	$	$	$	$	$	n/a	n/a
18	Total direct cost and indirect cost (Lines 15 + 17).....	18	$	$	$	$	$	$	$	$
19	Units of service provided all students. .(from school records).....	19								
20	Direct and indirect cost per unit of service..(Line 18/19).....	20	$.	$.	$.	$.	$.	$.	$.	$.
21	Units of service provided to Medicaid recipient students.....	21								
22	Total cost for Medicaid.(Line 20 x 21)..... $ (Sum of Line 22 Columns)	22	$	$	$	$	$	$	$	$

23 Required district match percentage..... . % 23

24 **Expenditures Available for matching Federal Medicaid funding** $ 24
(This is the amount to be entered on certification statement) Line 22 x 23

25	Description of proration bases used at lines 19 and 21.....	25								
	Recommended proration bases, other reasonable proration bases could be use		Face-to-face units 15 min = 1 unit	Face-to-face units 15 min = 1 unit	Face-to-face units 15 min = 1 unit	Face-to-face units 15 min = 1 unit	Face-to-face units 15 min = 1 unit	Face-to-face units 10 min = 1 unit	Miles	Cost of Equipment

33 Note on Account Numbers. At the option of the district or CESA, those accounts to which expenses are charged that are directly assignable to services provided to Medicaid recipient students can be assigned a unique project account code for identification.

Appendix 11
Electronic Media Claims (EMC) Screen

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 010193

EDS - WISCONSIN MEDICAID

BP NBR 33 L NAME 2 F NAME 2 MID 1A

PCN 26 OI 9 TPL 10 MSC 11 PA NBR 23

RP NBR 17 FP NBR 32 OP NBR

DIAG 1 21.1 2 21.2 3 21.3 4 21.4 5 21.5

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	24.3	A	B	D	D	D	K	E	F	G	C	I	H
2													
3													
4													
5													
6													
7													
8													
9													
10													

TOT BILL 28 OI PAID 29 PAT PAID 24.K NET BILL 30

Doc #1 Page #1 Field #6 **Form: MEDVENDR** **01-01-1993 10:17:35**

BENEFITS OF ELECTRONIC BILLING

One of the greatest benefits of electronic billing is that less information is required for processing. Less information means less room for error. The data elements that are not required on electronic claims include:

- claim indicator
- patient's date of birth
- patient's address
- patient's sex
- signature of provider
- provider's name and address

Other benefits of billing electronically include:

- free software
- improved cash flow
- lower detail denial rate
- flexible submission methods
- claim entry controlled by provider
- online edits

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at the address located in Section 3 of this handbook, or fill out the Electronic Information Request Form (Appendix 13) located at the back of this handbook.

Appendix 12
Electronic Media Claims (EMC) Screen (Completed)

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 010193
EDS - WISCONSIN MEDICAID

BP NBR 12345678 L NAME Recipient (Up to 12 ch.) F NAME Im MID 1234567890
PCN 1234JED OI D TPL __ MSC ___ PA NBR _____
RP NBR _____ FP NBR _____ OP NBR _____
DIAG 1 1234 2 5678 3 _____ 4 _____ 5 _____

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	010196	0203	0	W6020				1	12345	400	1		
2													
3													
4													
5													
6													
7													
8													
9													
10													

TOT BILL 12345 OI PAID 000 PAT PAID _____ NET BILL 12345

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Appendix 13
Wisconsin Medicaid
Electronic Information Request Form

The Wisconsin Medicaid Program offers many different methods for submitting your Medicaid claims electronically. All of this information is available for downloading from the EDS bulletin board system (EDS-EPIX). By downloading you will be able to obtain this information within minutes at your convenience. Please refer to Appendix 14 of this handbook for the "Quick Guide to Obtaining Medicaid Electronic Claim Information" to assist you with the downloading process.

_____ **ECS (Electronic Claim Submission)** EDS supplies free software that runs on a stand alone IBM compatible computer and uses a Hayes compatible modem. The electronic record layouts are also available to create your own data files containing Wisconsin Medicaid claim information.
_____ 3 1/2" diskette _____ 5 1/4"diskette

_____ **3780 Protocol** 3780 protocol is an IBM communication protocol that enables mini or mainframe computers to send claim data files to EDS.

_____ **Magnetic Tape** Providers with the capability to create their claim information on tape can submit those tapes to EDS. EDS also provides Remittance Advice Information on magnetic tape.

_____ **MicroECS** MicroECS allows providers to send their data files to EDS using most basic telecommunication packages with any one of six protocols available, and accepts line speeds up to 14,400 bps.

_____ **Reformatter** The Reformatter is software designed for EDS that enables providers to enjoy the benefits of electronic billing without making costly changes to their existing billing system. Instead of printing claims on paper, claims are printed to a data file on a personal computer and transmitted to EDS. EDS reformats the data into the required electronic record format and brings the claims into the Wisconsin Medicaid processing system.

_____ Please send me aditional information on EDS' bulletin board system (EDS-EPIX).

If you are unable to download and would like information on electronic claim submission, please check off the above method(s) you are interested in and complete the following:

Name: _____ Provider Number: _____

Address: _____ Type of Service: _____

_____ Contact Person: _____

_____ Phone Number: _____

Please return to: EDS
6406 Bridge Rd.
Madison, WI 53784-0009
(608) 221-4746

Appendix 14
Quick Guide to Obtaining Medicaid Electronic Claim Information

This is a quick guide to retrieving and installing EDS' Electronic Claim Submission software using EDS-EPIX.

1. If you wish to obtain EDS Software, create a subdirectory on your hard drive for your Electronic Claim Submission software called "EDS". At the DOS command prompt type:

   C: <Enter>
   CD\ <Enter>
   MD EDS <Enter>

2. Set up your communication software to dial EDS-EPIX. You may need to program your software to dial with the following settings:

   Phone Number: (608) 221-4746 **Stop Bits:** 1
   Baud Rate: 9600 (maximum) **Duplex:** Full
   Parity: None **Protocol:** XMODEM (recommended)
   Data Bits: 8 **Terminal Emulation:** ANSI

3. Dial into EDS-EPIX. When you go through this initial logon, we recommend you select Xmodem/CRC as your default protocol.

4. Select option "F" (File Directories) from the main menu and then view the "ECS Software and Manuals for New Users" or the "Record Layout and Manual Updates" directory. Choose the name of the file you need to download. If you need help deciding which file you need, go back to the main menu and view Bulletin #2 or #3 for more information. When you have chosen a file, write down the file name (you will need it to download).

5. Select option "D" (Download a File) from the main menu, and type the file name you chose in step 4. Next, follow the download instructions in the user manual for your communications software package. This basically involves telling your communications software package that you wish to "Receive a File", choosing a transfer protocol, and specifying the name and directory path of the file. If you fail to specify the directory path with the file name, the file will be downloaded into the default download directory for your communications software.

6. When you have downloaded your file, select "G" (Goodbye) to end your EDS-EPIX session, quit your communication software, and return to DOS.

7. Go to the subdirectory you specified in your path and look for your download file. It should be listed when you list the directory.

8. If the download file is in the directory, you will need to decompress the file. At the DOS command prompt type the name of the download file without the ".EXE" extension. For example, for School Based Services software, at the DOS command prompt type:

   MEDVNDRU <Enter>

9. This will extract your software and manual(s).